

<i>SERFF Tracking Number:</i>	<i>FRCS-125731086</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39651</i>
<i>Company Tracking Number:</i>	<i>4965</i>		
<i>TOI:</i>	<i>H14G Group Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14G.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>Merchandise Group Policy HIP</i>		
<i>Project Name/Number:</i>	<i>Pan-Am/63/63</i>		

Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: Merchandise Group Policy – SERFF Tr Num: FRCS-125731086 State: ArkansasLH
HIP

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed

State Tr Num: 39651

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: 4965

State Status: Approved-Closed

Filing Type: Form

Co Status: None

Reviewer(s): Rosalind Minor

Author: Kevin Wiggs

Disposition Date: 07/18/2008

Date Submitted: 07/18/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Pan-Am/63

Status of Filing in Domicile: Not Filed

Project Number: 63

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Not filed in domicile state (LA).

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Discretionary, Trust

Filing Status Changed: 07/18/2008

State Status Changed: 07/18/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We have been retained by Pan-American Life Insurance Company to file the above-referenced forms for approval in your state.

These forms are new and do not replace any previously approved forms.

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The Company plans to issue this certificate under a Group Hospital Indemnity Policy issued to a group trust sitused in Illinois.

The Company believes that the issuance of the group health policy is not contrary to the best interests of the public.

The forms are written in clear and simplified language and have passed the Flesch Reading Ease test. The forms are in final format subject only to changes in font style, margins, page numbers, ink, and paper stock. Printing standards will not be less than those required under your law.

Our fee of \$100 has been sent by EFT on this same date. This fee is based on the Company's state of domicile.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

(This filing was made by a third party - FC01)

Kevin Wiggs, Compliance Specialist	kevin.wiggs@firstconsulting.com
1020 Central	(800) 927-2730 [Phone]
Kansas City, MO 64105	(816) 391-2755[FAX]

Filing Company Information

Pan-American Life Insurance Company	CoCode: 67539	State of Domicile: Louisiana
601 Poydras	Group Code: 525	Company Type:
New Orleans, LA 70130	Group Name: Pan-American Life Group	State ID Number:
(504) 566-3781 ext. [Phone]	FEIN Number: 72-0281240	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	Yes
Fee Explanation:	LA fee of \$100 per policy.

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Per Company:	No		

SERFF Tracking Number: *FRCS-125731086* *State:* *Arkansas*
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TOI: *H14G Group Health - Hospital Indemnity* *Sub-TOI:* *H14G.000 Health - Hospital Indemnity*
Product Name: *Merchandise Group Policy HIP*
Project Name/Number: *Pan-Am/63/63*

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	\$100.00	07/18/2008	21486845

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<i>Project Name/Number:</i>	<i>Pan-Am/63/63</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/18/2008	07/18/2008

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<i>Project Name/Number:</i>	<i>Pan-Am/63/63</i>		

Disposition

Disposition Date: 07/18/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *FRCS-125731086* State: *Arkansas*
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 Project Name/Number: *Pan-Am/63/63*

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Fee Schedule	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Group Hospital Indemnity Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Amendatory Rider	Approved-Closed	Yes

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Form Schedule

Lead Form Number: USH0002C

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	USH0002C	Certificate	Group Hospital Indemnity Certificate	Initial		54	Generic Retailer HI Certificate 4-8-08_dist_bkmrkd.pdf
Approved-Closed	USHSB0002P/C	Schedule Pages	Schedule of Benefits	Initial		72	US Hispanic HI Schedule of Benefits P-C 4-8-08_dist.pdf
Approved-Closed	USH0002C-R(AR)	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Rider	Initial		51	AR Amendatory Rider.pdf

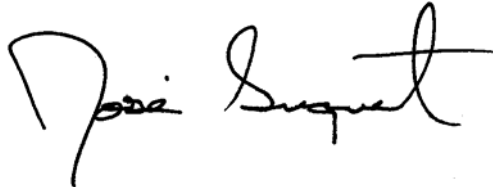
CERTIFICATE OF COVERAGE

**Under the
Plan Named in the Schedule of Benefits
for Group Members of the Plan Sponsor
named in the Schedule of Benefits**

**Underwritten by
PAN-AMERICAN LIFE INSURANCE COMPANY
New Orleans, Louisiana**

Pan-American Life Insurance Company has issued a Plan covering certain Group Members of the Plan Sponsor. The benefits of the Plan are described in this Certificate/booklet. Final interpretation is governed by the Plan. This Certificate/booklet replaces any and all Certificates previously issued for the Group Members covered under the Plan. This Certificate/booklet describes the Plan in effect as of the Effective Date shown in the Schedule of Benefits. This Certificate/booklet is the Group Member's Certificate of Coverage only when the Group Member is covered under the Plan.

PAN-AMERICAN LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Jose Siquet". The signature is fluid and cursive, with a large initial "J" and a long horizontal stroke at the end.

**President and Chief Executive Officer
Chairman of the Board**

NOTICE CONCERNING YOUR PLAN

The benefits and provisions of the Plan are described in this Certificate. Additional benefits and provisions may apply based on the requirements of the state where the Plan is issued and the state where You live. These state benefits and provisions are described in separate amendments.

GROUP HOSPITAL INDEMNITY

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SECTION 1 DESCRIPTION OF BENEFITS

We will pay benefits shown in the Schedule of Benefits for a Covered Person, subject to all applicable conditions and exclusions, for a Hospital Stay for a Covered Person in connection with a Covered Accident or a Covered Sickness. [Subject to the Waiting Period applicable to a Covered Sickness,] We will pay the daily Benefit Amount shown in the Schedule of Benefits for each covered over-night Hospital Stay. All benefit amounts and any applicable maximums are shown in the Schedule of Benefits, and are payable on a per Covered Person basis.

SECTION 2 DEFINITIONS

The words defined below and capitalized have the meanings set forth below.

COVERED ACCIDENT means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Hospital Stay and meets all of the following conditions:

1. occurs while Covered Person is insured under this Plan;
2. is not contributed to by disease, sickness, or mental or bodily infirmity; and
3. is not otherwise excluded under the terms of this Plan.

COVERED GROUP MEMBER means a Group Member who has met the enrollment requirements of the Policy, has been accepted for enrollment by Us, and for whom all premiums have been paid.

COVERED PERSON means a Group Member or Eligible Dependent (if the Plan provides for dependent coverage) who has met the enrollment requirements of the Policy, has been accepted for enrollment by Us, and for whom all premiums have been paid.

COVERED SICKNESS means a bodily disorder, disease, physical condition, [pregnancy], or complication of pregnancy that:

1. is first manifested while the Covered Person is insured under this Plan (or is not subject to a pre-existing condition exclusion); and
2. is not otherwise excluded under the terms of this Policy.

A Covered Sickness includes congenital defects and birth abnormalities. [A Covered Sickness does not include any mental or nervous disorder, alcoholism, or substance abuse.]

[**ELIGIBLE DEPENDENT** means any of the following:

1. the Covered Group Member's lawful spouse between 18 and 64 years of age; and
2. the Covered Group Member's unmarried natural or step child who:
 - a. is less than [25] years old; or
 - b. becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. This insurance will continue for as long as the Covered Group Member's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more than once a year after the child attains the age [25]; and
3. an unmarried child less than [25] years old that is adopted by or placed for adoption with, or is party in a suit for adoption by, You; and

4. an unmarried child that is required to be provided coverage by You or Your spouse under the terms a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]); and
5. Your unmarried grandchild who:
 - a. is less than 25 years old; and
 - b. is Your dependent, for federal income tax purposes, at the time request for the grandchild's coverage is made.]

GROUP MEMBER means any individual that is a customer of a retailer that has agreed to participate in the Policy, who maintains an existing open account credit relationship with the retailer or its affiliates or who has purchased goods, services, or financial products from the retailer or any of its affiliates within 3 years of the date the individual enrolls in coverage under this Plan.

HOSPITAL means an institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis; and
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a hospital, including a skilled nursing unit, for:

1. rehabilitation, convalescent, custodial, or nursing care; or
2. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

HOSPITAL STAY means a confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident or a Covered Sickness.

PHYSICIAN means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person who is not:

1. living in the Covered Person's household; or
2. a parent, sibling, spouse or child of the Covered Person.

PLAN means the benefit plan elected by the Plan Sponsor, as described in the Schedule of Benefits.

PLAN SPONSOR means the entity identified in the Schedule of Benefits.

[PRE-EXISTING CONDITON means any injury sustained in an accident that occurred, or a sickness that first manifested itself, before the Covered Person's effective date of coverage under this Plan and for which the Covered Person has received any diagnosis, medical advice, care or treatment within the 6-month period immediately preceding his effective date of coverage.] [A pregnancy that existed on a Covered Person's effective date will not be considered a Pre-Existing Condition.]

[WAITING PERIOD means that period of time after the Covered Person becomes insured under the Plan for which a benefit is payable for a Hospital Stay arising from a Covered Accident but for which a benefit is not payable for a Hospital Stay arising from a Covered Sickness.]

WE/US/OUR/COMPANY means Pan-American Life Insurance Company.

YOU/YOUR means a Covered Group Member insured under the Plan that has received this Certificate.

SECTION 3 COVERED PERSON PROVISIONS

CLASSES OF PERSONS ELIGIBLE

To be eligible for coverage, You must be at the time of enrollment a Group Member between 18 and 64 years of age [or an Eligible Dependent of a Covered Group Member.]

WHEN A GROUP MEMBER BECOMES INSURED

You will become insured [on the first day of the month] following the date that You agree to enrollment under the Plan, [and] are accepted for enrollment by Us, [and have paid to Us the premium for the first month of coverage under the Plan].

[WHEN AN ELIGIBLE DEPENDENT BECOMES INSURED]

Dependent insurance will become effective on the latest of:

1. the Covered Group Member's effective date if the dependent is eligible as of the Covered Group Member's effective date and the Covered Group Member enrolls and pays premium for the dependent on or before that date; or
2. the date the Covered Group Member enrolls a dependent if the dependent becomes eligible after the Covered Group Member's effective date and the enrollment and premium are received within 31 days after the date the dependent becomes eligible; or
3. as provided on the Schedule of Benefits.

In no case will coverage for eligible dependents take effect before the Covered Group Member's. No dependent will be covered unless application has been made and the correct premium has been paid.

Insurance becomes effective for a newborn dependent child of a Covered Group Member automatically from the moment of the child's live birth. Insurance for that dependent child automatically ends 31 days later unless the Covered Group Member has a spouse or other dependent children insured under the Plan or makes a request to cover the child and pays the required initial premium, during the child's lifetime.

A minor child who comes under the charge, care and control of the Covered Group Member while the Plan is in force is covered provided the Covered Group Member files a petition to adopt. The coverage of such child will be the same as provided for other members of the Covered Group Member's family. Such child shall be covered from the date of placement in the Covered Group Member's home if the Covered Group Member applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such

child's coverage will not be subject to any pre-existing conditions limitations provided by the Policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.]

SECTION 4 TERMINATION PROVISIONS

PLAN PERIOD

This Plan takes effect on the Plan Effective Date as shown in the Schedule of Benefits. The Plan will continue in force until terminated in accordance with the provisions of this Plan.

POLICY TERMINATION

We may cancel this Plan upon 30 days advance written notice to the Plan Sponsor. Plan Sponsor may cancel this Plan at any time by giving Us written notice in advance of such cancellation. The effective date of termination will be the date We receive such notice, or a later date as shown in the notice.

TERMINATION OF INSURANCE

Your insurance will cease on the earliest date below:

1. The date the Policy is terminated; or
2. The date the Plan is terminated; or
3. The last day of the month following the date You fail to make a required premium contribution, if premium contributions are required; or
4. The date You reach 65 years of age; or
5. The date You commence serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by us pro-rata for any period of active-full time duty);
6. With respect to an Eligible Dependent, the next premium due date after the first of the month following the date the person no longer meets the definition of an Eligible Dependent or such earlier time that the Covered Group Member elects to terminate the Eligible Dependent's participation in the coverage.

Termination will not affect a claim incurred while coverage was in effect.

SECTION 5 EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any Hospital Stay arising from a Covered Accident or Covered Sickness which, directly or indirectly, in whole or in part, is caused by or results from or involves any of the following:

1. [a Hospital Stay during which the Covered Person gives birth]
2. [a Hospital Stay for the treatment of a mental or nervous disorder, alcoholism, or substance abuse];
3. any intentionally self-inflicted injury or sickness;
4. participation in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless the Covered Person acted in a lawful manner;
5. committing, attempting to commit, or taking part in a felony or assault;
6. participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding;
7. air travel except
 - a. as a fare-paying passenger on a commercial airline on a regularly scheduled route

- b. on a charter flight operated by a scheduled airline, or;
 - c. as a passenger for transportation only and not as a pilot or crew member;
- 8. an act of war;
 - 9. [an accident or sickness arising out of and in the course of any occupation for compensation, wage or profit; or expenses which are payable under Worker's Compensation Law or similar law, whether or not application for such benefits have been made];
 - 10. any Hospital Stay during a period of time that insurance for a Covered Person is not in force;
 - 11. any Hospital Stay outside the United States, its possessions [or the countries of Canada and Mexico].

[PRE-EXISTING CONDITION LIMITATION]

We will not pay any benefits for a Hospital Stay for a Covered Person for treatment of a Pre-Existing Condition until the Covered Person has been enrolled for coverage under the Plan for a continuous [12] month period. Any period during which benefits are not payable for a Pre-Existing Condition will be reduced by the number of months during which the Covered Person was insured by another similar plan under which coverage ended not more than 63 days before the Covered Person became insured under the Plan.]

SECTION 6 CLAIM PROVISIONS

NOTICE OF CLAIM

Written or authorized electronic notice of claim must be given to Us within 31 days after a Hospital Stay or as soon as reasonably possible. If written or authorized electronic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Office in New Orleans, Louisiana, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the insured's name, address, and Plan number.

PROOF OF LOSS

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. Failure to furnish proof within the time frame required will not void or reduce a claim if the proof is furnished as soon as it is reasonably possible to do so. Except in the event of legal incompetence, this extension of the time limit shall in no event exceed one (1) year.

CLAIM FORMS

We will send forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the same time fixed in this Plan for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

TIME OF PAYMENT OF CLAIM

We will pay benefits due under this Plan for any covered Hospital Stay immediately upon receipt of due written or authorized electronic proof of such loss.

PAYMENT OF CLAIMS

All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated will be payable to the Covered Person or his estate.

SECTION 7

PREMIUM PROVISIONS

PREMIUM PAYMENT

Premiums are payable at the Home Office of the Company [or to an appointed licensed agent or licensed administrator of the Company] on or before each premium due date.

PREMIUM DUE DATE

The first premium will be due for a Covered Person on the [first] [same] day of the month coverage becomes effective and the [first] [same] day of each subsequent month for which the coverage remains in force.

CHANGES IN PREMIUM RATES

The monthly premium rates may be changed by Us from time to time if We give the Plan Sponsor at least thirty-one (31) days advance written notice.

INCORRECT PREMIUM PAYMENT

Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest.

GRACE PERIOD

A Grace Period of 31 days will be granted for payment of required premiums due after the first premium, unless:

1. We do not intend to renew the Plan beyond the period for which premium has been accepted; and
2. written notice of Our intention not to renew is delivered to the Plan Sponsor at least 30 days before the premium is due.

This Plan will be in force during the Grace Period. If the required premiums are not paid during the Grace Period, insurance will end on the last day of the Grace Period. An individual Grace Period of 31 days, applicable when a Covered Person remains eligible under this Plan, will be granted for payment of required premiums. A Covered Person's insurance under this Plan will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of the premium due. If no such claims are incurred and the premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

SECTION 8

GENERAL PROVISIONS

INCONTESTABILITY

We will not contest the Policy after two (2) years from the date of issue except for failure to pay premium. No statement made by an Covered Person will be used to deny a claim after the person's coverage has been in force for a period of two (2) years during the Covered Person's life; then only if the statement is made in writing and signed by the Covered Person.

STATEMENT NOT WARRANTIES

All statements made by the Policyholder or by a Covered Person will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Covered Person to obtain insurance will be used to avoid or reduce the insurance unless:

1. It is made in writing;
2. It is signed by the Policyholder or the Covered Person; and
3. A copy is sent to the Covered Person or the Covered Person's beneficiary.

ENTIRE CONTRACT; POLICY CHANGES

The entire contract will be made up of the Plan and the application of the Policyholder, a copy of which is attached to the Plan. Changes may be made in the Plan only by amendment signed by the Plan Sponsor and by the Company acting through one (1) of its officers. No agent may change or waive any terms of the Plan.

CLERICAL ERROR

Clerical error will not void insurance otherwise validly in force nor will it keep in force insurance which otherwise would cease.

LEGAL ACTIONS

No attempt to recover under the Plan through legal actions may be made until at least sixty (60) days after written proof of loss has been furnished as required by the Plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

10 DAY RIGHT TO EXAMINE CERTIFICATE

If You do not like the Certificate for any reason; it may be returned to Us within 10 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

ASSIGNMENT

The rights and benefits provided by the Plan, except as provided herein, may not be assigned. The payee may, after a benefit has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid. Any other attempt will be void.

CONFORMITY WITH STATUTES

Any provisions in conflict with the requirements of any state or federal law that applies to this Plan are automatically changed to satisfy the minimum requirements of such laws.

NOT WORKERS' COMPENSATION INSURANCE

This Plan is not in place of and does not affect any requirements for coverage under any Worker's Compensation Law.

SCHEDULE OF BENEFITS

We will provide the benefits shown.

Group Number:	XXXXXX
Plan Sponsor:	Group Name
Plan Sponsor Address:	Group address
Effective Date:	group effective date
Plan Anniversary Date:	anniversary

BENEFITS AND AMOUNT OF BENEFITS

COVERED SICKNESSES

DAILY HOSPITAL STAY BENEFIT AMOUNT

[\$100] [\$200] [\$300] [\$400] [\$500], up to a calendar Year maximum of [30] [60] days for a Covered Sickness.

[\$100] [\$200] [\$250] [\$300] [\$400] [\$500] [\$600] [\$750], up to a calendar Year maximum of [30] [60] days for a Covered Sickness while in an Intensive Care Unit.

[Maternity will be covered as any other Covered Sickness]

COVERED ACCIDENTS

DAILY HOSPITAL STAY BENEFIT AMOUNT

[\$100] [\$200] [\$250] [\$300] [\$400] [\$500] [\$600] [\$750], up to a calendar Year maximum of [30] [60] days for a Covered Accident.

[\$100] [\$200] [\$250] [\$300] [\$400] [\$500] [\$600] [\$750], up to a calendar Year maximum of [30] [60] days for a Covered Accident, while in an Intensive Care Unit.

WAITING PERIOD:

For a Hospital Stay arising from a Covered Accident, there is no waiting period. [For a Hospital Stay arising from a Covered Sickness, [30] [60] [90] [120] days from the Covered Group Member's effective date of coverage.][For a Hospital Stay arising from a pregnancy, none.]

[None]

IT IS OUR INTENT TO PAY BENEFITS IN ACCORDANCE WITH THE LAWS OF THE STATE WHERE THE GROUP POLICY IS ISSUED, UNLESS OTHERWISE FORBIDDEN BY THE LAWS OF THE STATE WHERE THE COVERED PERSON LIVES. IF THERE IS A CONFLICT BETWEEN ANY PROVISION IN THE PLAN AND THE APPLICABLE STATE LAW, THE STATE LAW WILL PREVAIL.

Form No. USHSB0002P/C

PAN-AMERICAN LIFE INSURANCE COMPANY

PAN-AMERICAN LIFE CENTER

601 POYDRAS

New Orleans, Louisiana 70130

TOLL FREE: 1-877-569-3075

ARKANSAS AMENDATORY RIDER

With respect to Arkansas Certificateholders only, and in spite of anything in the Policy/Certificate to the contrary, this Rider changes the Policy/Certificate to which it is attached as follows:

1. The following notice is added:

CONSUMER NOTICE

If you have any questions or concerns about this coverage, you should contact Us at 1-877-569-3075, or at the address or phone number shown in your Policy. If we are not able to provide a satisfactory resolution to the inquiry, you may contact the:

Arkansas Department of Insurance

Consumer Services

1200 W. Third Street

Little Rock, AR 72201-1904

800-852-5494

501-371-2640

2. Item 2.b. under the definition of "Eligible Dependent", found in Section 2, Definitions, is deleted and replaced with the following:
 - b. becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. We must receive proof of incapacity in order for coverage to continue. If proof that the child was incapacitated from the date the child attained the limiting age is not submitted before or at the time proof of loss is submitted for a claim, coverage will not be extended past the date the child attained the limiting age. Once coverage has been continued due to the child's incapacity, We must receive proof each year that such capacity continues without interruption.
3. The Newborn Child and Adopted Child sections, found in Section 3, Covered Person Provisions, are amended as follows:

The Newborn Child provision is amended to allow 90 days for notice rather than 31 days. In addition, the Newborn Child section is amended to provide that coverage for a newborn child shall be provided for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas, as well as any testing of newborn infants hereafter mandated by law, and routine nursery care and pediatric charges for a well newborn child for up to five full days in a Hospital

nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

The Adopted Child provision is amended to provide that the coverage for an adopted child shall begin on the date of the filing of a petition for adoption if the Covered Group Member applies for coverage within 60 days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor. The coverage shall terminate upon the dismissal or denial of a petition for adoption.

4. Exclusion 8, found in Section 5, Exclusions and Limitations, is amended to clarify that such exclusion will not be construed to apply to terrorist acts.

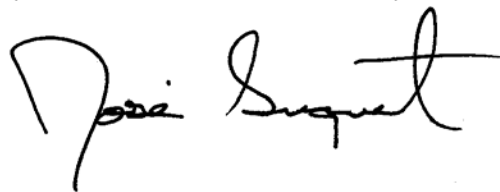
This Rider does not change, waive or extend any part of the Policy/Certificate other than as set forth above. All provisions not changed by this Rider shall remain as stated in the Policy/Certificate.

This Rider is effective at the same time as the Policy/Certificate, unless a later date is shown below.

(_____), 20__

Signed by the Company:

{ _____ }



President and Chief Executive Officer

<i>SERFF Tracking Number:</i>	<i>FRCS-125731086</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39651</i>
<i>Company Tracking Number:</i>	<i>4965</i>		
<i>TOI:</i>	<i>H14G Group Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14G.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>Merchandise Group Policy HIP</i>		
<i>Project Name/Number:</i>	<i>Pan-Am/63/63</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-125731086 State: Arkansas
Filing Company: Pan-American Life Insurance Company State Tracking Number: 39651
Company Tracking Number: 4965
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Merchandise Group Policy HIP
Project Name/Number: Pan-Am/63/63

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	07/18/2008
Comments:		
Attachments:		
AR CoC.pdf		
AR RDB.pdf		
AR Authorization.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	07/18/2008
Comments:		
Attachment:		
Adoption and Participation Agreement-HI 4-8-08.pdf		
Satisfied -Name: Fee Schedule	Review Status: Approved-Closed	07/18/2008
Comments:		
Attachment:		
AR Fee Schedule.pdf		
Satisfied -Name: Statement of Variability	Review Status: Approved-Closed	07/18/2008
Comments:		
Attachment:		
Statement of Variability.pdf		


STATE OF ARKANSAS
CERTIFICATION OF COMPLIANCE

Company Name: Pan-American Life Insurance Company

Form Title(s): Group Hospital Indemnity Certificate
Schedule of Benefits
Amendatory Rider

Form Number(s): USH0002C
USHSB0002P/C
USH0002C-R(AR)

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Daniel LaGrone
Vice President, Associate General Counsel

July 11, 2008

Date

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Pan-American Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
USH0002C	53.7
USHSB0002P/C	71.9
USH0002C-R(AR)	50.9



Daniel LaGrone
Vice President, Associate General Counsel

July 11, 2008

Date



Daniel E. LaGrone

Vice President
Associate General Counsel

601 Poydras Street
New Orleans, LA 70130
Telephone 504.566.3781
Facsimile 504.566.3787

Diagrone@panamericanlife.com

July 26, 2007

Ms. Julie Benafield Bowman
Commissioner
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AK 72201-1904

AUTHORIZATION

This letter, or a copy thereof, authorizes the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, and its employees, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

PAN-AMERICAN LIFE INSURANCE COMPANY

By: 

Title: Associate General Counsel

ADOPTION AND PARTICIPATION AGREEMENT

COVERAGE UNDERWRITTEN BY:

PAN-AMERICAN LIFE INSURANCE COMPANY

TO: The Trustees of the Merchandiser Group Policy Trust (called the "Trustee" within):

The undersigned Plan Sponsor requests to become a Participant under the Trust and to have eligible Group Members who meet the eligibility classifications under Group Policy No. [] become Covered Persons under the terms of the Policy.

In consideration of the granting of this request:

THE PLAN SPONSOR AGREES:

1. To be bound by all the terms, provisions, conditions, and limitations of the Policy and the Trust, as they may be amended; and
2. To assume all obligations of a Participating Plan Sponsor.

IT IS UNDERSTOOD AND AGREED THAT:

1. The Policy may be amended or terminated by the Company and the Trustee. If the Policy is to be terminated for all Participating Plan Sponsors, the Company will give 30 days written notice to the Trustee prior to the termination date. The Company may also terminate the Plan upon 30 days notice to the Plan Sponsor. Each Participating Plan Sponsor will be advised of the termination date in advance written notice.
2. All premiums shall be paid to the Company or such other party designated by the Company.
3. All necessary administrative information concerning all Covered Persons shall be subject to the provisions of the Plan and shall be furnished to us by the Plan Sponsor;
4. This application is subject to the approval of the Pan-American Life Insurance Company at its Home Office and that nothing contained herein shall be binding upon said Company until this application has been so approved;
5. All benefits will be in accordance with the benefits proposed and agreed upon between Pan-American Life Insurance Company and the Plan Sponsor as set forth in the plan.
6. This fully completed and signed Agreement, as well as any Supplements attached to it, will be attached to and made a part of the Policy.

Plan Sponsor Information
Plan Sponsor Name: _____
Plan Sponsor Address: _____ _____
Plan Sponsor Tax ID#: _____
Does the Plan Sponsor contribute premiums toward this plan? _____

If yes, specify the percentage. _____%.

Requested Effective Date: _____

Group Benefit Selection

	PLAN 1	PLAN 2	PLAN 3
BENEFIT			
Daily ICU Benefit-Covered Sickness	Amount _____	Amount _____	Amount _____
Daily ICU Benefit-Covered Accident	Amount _____	Amount _____	Amount _____
Daily Benefit Hospital Stay-Covered Sickness	Amount _____	Amount _____	Amount _____
Daily Benefit Hospital Stay—Covered Accident	Amount _____	Amount _____	Amount _____
Waiting Period	_____ Days	_____ Days	_____ Days
Covered Person Only Initial Rate	\$ _____ per month	\$ _____ per month	\$ _____ per month
Covered Person Plus Children Initial Rate	\$ _____ per month	\$ _____ per month	\$ _____ per month
Covered Person Plus Spouse Initial Rate	\$ _____ per month	\$ _____ per month	\$ _____ per month
Family Coverage Initial Rate	\$ _____ per month	\$ _____ per month	\$ _____ per month

PLAN SPONSOR (HEREIN REFERRED TO AS “WE”) RESPONSIBILITIES UNDER THIS PLAN

We agree: (1) to maintain the records necessary to the administration of the Policies; (2) report additions, changes, terminations and other information necessary to the administration of the Policies to the Insurer within 30 days after the effective date of such additions, changes and terminations; and (3) notify all Plan Participants of any termination or rescission of coverage which affects them and refund the appropriate premium.

By the signature below of its duly authorized representative, the proposed plan sponsor, hereby applies to participate in the Merchandiser Group Policy Trust, and in the Pan-American Life Insurance Company policy or policies of group insurance; and the proposed plan sponsor understands and agrees that its participation shall be subject to the provisions set forth herein.

We understand that the coverage provides only Daily Hospital Indemnity Benefits.

Dated at _____ this _____, 20_____.

Witness _____ Plan Sponsor: _____

(original signature required)

Signed by: _____

NOTICE CONCERNING YOUR RIGHTS OF PRIVACY AS A CONSUMER

Pan-American Life Insurance Company collects nonpublic information about you from the following sources:

- Information we receive from you in applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

We do not disclose any nonpublic information about our customers to anyone, except as permitted by law.

We restrict access to your nonpublic personal information to those Company Employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Fraud Warning for California Residents:

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Fraud Warning for Florida Residents:

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning for District of Columbia Residents:

Warning it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

Fraud Warning for Kentucky Residents:

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Fraud Warning for New Jersey Residents:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Fraud Warning for Pennsylvania Residents:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Fraud Warning for Tennessee and Virginia Residents:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ARKANSAS FEE SCHEDULE

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: Pan-American Life Insurance Company

NAIC Code: 67539

Contact Person & Telephone: Kevin Wiggs, Compliance Specialist
1-800-927-2730 Ext. 2736

First Consulting & Administration, Inc., 1020 Central, Suite 201, Kansas City, MO 64105

INSURANCE DEPARTMENT USE ONLY

ANALYST: _____ **AMOUNT:** _____ **ROUTE SLIP:** _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* x \$50 = \$
**Retaliatory = \$100.00

Life and/or Disability - filing and review of each rate filing or loss ratio guarantee filing per each insurer.

* x \$50 = \$
**Retaliatory = \$

Life and/or Disability Policy, Contract or Annuity Form: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the base form.

* x \$20 = \$
**Retaliatory = \$

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* x \$25 = \$
**Retaliatory = \$

AMENDED CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.

* x \$400 = \$

Filing to amend Certificate of Authority

*** x \$100 = \$

*** THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

**** THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

***** THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SECTION 23-61-401.**

STATEMENT OF VARIABILITY

This is a listing of items that relate to the use of variable brackets within the policy/certificate/rider forms attached.

AT NO TIME WILL ANY VARIABLES BE USED TO CHANGE ANY PROVISION IN A MANNER THAT IS NOT IN COMPLIANCE WITH APPLICABLE STATE OR FEDERAL LAW.

Page and section numbers (if used) have been marked variable-

Variables will be limited to page and section numbers. Where page or section numbers are used in the text, the page or section number may be changed to refer to the proper page or section as appropriate.

Numbers-

All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs-

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Definitions-

The Definition Section is marked variable. Unnecessary definitions will be deleted based on applicability to the particular plan design selected by an insured.

Other variables-

- Other items that customarily vary according to the policyholder's specific plan of insurance.
- The Schedule of Benefits shall be considered as variable to illustrate the specific terms of coverage offered by the company and chosen by the policyholder.
- We also reserve the right to amend the policy/certificate/rider forms to fix any minor typographical errors we may have neglected to find prior to submitting for approval.